GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Rhonda Medows, MD, Commissioner *Sonny Perdue, Governor*

2 Peachtree Street, NW
Managed Care – 36th Floor
Atlanta, GA 30303-3159
www.dch.georgia.gov

Dear Provider:

Thank you for your interest in becoming a Georgia Better Health Care (GBHC) primary care case manager for Medicaid and PeachCare for Kids members.

Included in the enrollment package are the following:

- Instructions
- GBHC Application Addendum
- GBHC Attestation Statement
- GBHC After-Hours Telephone Coverage & Provider Accessibility Agreement

Georgia Better Health Care providers also must be separately enrolled in an appropriate Medicaid service program, e.g., physician, nurse practitioner, or health center. If you are not currently enrolled in one of these programs, you will need to complete that enrollment package as well. You may enroll online at the Georgia Health Partnership website: Http://www.ghp.georgia.gov, or you may contact Provider Enrollment at (404) 298-1228 or (800) 766-4456.

Physicians and providers who enroll as individuals in Georgia Better Health Care must complete the GBHC Application Addendum and the Statement of Participation, as well as the After-Hours Telephone & Physician Accessibility Agreement. Group practices wishing to enroll with GBHC must complete a single GBHC Application Addendum as well as the After-Hours Agreement, both to be signed by a representative of the practice. Each individual provider in the group who wishes to participate in Georgia Better Health Care must complete an Attestation Statement. It is not required that every member of a group practice be enrolled in GBHC in order for the group to participate in the program. A separate GBHC Application Addendum must be completed for each practice location.

If you require any assistance in completing this package or need any additional information, please do not hesitate to call Provider Enrollment at (404) 298-1228 or (800) 766-4456. We look forward to your enrollment and participation in Georgia Better Health Care.

Sincerely,

Kathrine R. Driggers

Kathrine R. Driggers, Chief
Managed Care and Quality

KD:tm

Instructions for Completing

Georgia Better Health Care (GBHC) Application Addendum, Statement of Participation and After-Hours Coverage & Provider Accessibility Agreement

PRACTICE INFORMATION –(Page one of Application Addendum)

Practice Name:	Enter the name of the physician. If the application is for a group practice, enter the name of the practice here. If a physician is planning on future expansion, a group name may be more appropriate.
Practice Address & Telephone Numbers:	Enter the street address of your office or business. A post office box is **not** acceptable. **A separate addendum is required for each location**. This address will be printed on the GBHC member's Medicaid card. Enter the area code and phone number members may call to schedule an appointment AND the area code and telephone number members may call after regular office hours to reach a doctor or other medical personnel. These numbers will be printed on the GBHC member's Medicaid card.
Mail-To Address:	Enter the address to which correspondence regarding this application can be sent. Either a street address or a post office box is acceptable.
County:	Enter the name of the county where the practice is located.
Tax ID/SSN:	Enter the Tax Identification Number (TIN) of the payee. If the payee is an individual provider, the Social Security Number (SSN) can be used instead of a TIN.
Accepting New Patients:	Check *Accepting New Patients* if you wish to accept new patients through the auto-assignment process or by patients selecting you as their primary care provider. **GBHC makes no implicit or explicit guarantee of member enrollment numbers.**
Established Patients Only:	Check *Established Patients Only* if you wish to case manage only those patients already established with your practice. DCH recommends that providers reach a minimum of one hundred (100) members before a practice or location can be closed to new members. If you check this option, GBHC will not assign patients to your practice after the minimum has been met. Members must complete a **Provider Selection Form** (*formerly Established Patient Only (EPO) form*) requesting assignment to your practice. This form must be signed by the member and submitted to GBHC Member Services. GBHC will mail the form upon request from the PCP.
Patient Type:	Indicate the age range and gender(s) of patients you wish to case manage. This designation determines the type of patients matched to your practice in the auto-assignment process.
Contact Person:	Enter the name, title, telephone, and fax number of the person in your office that GBHC may contact if there are any questions regarding this application addendum or other Georgia Better Health Care questions.
Full Time Equivalent (FTE):	One (1) FTE equals a minimum of 30 hours per week delivering patient care. Enter the number of FTEs for physicians, nurse practitioners, and/or physician assistants that will deliver primary care to GBHC patients.
Check "yes" or "no":	Has Georgia Medicaid ever placed any member of your practice on prepayment review status? **If "yes", please attach details.**

PRACTICE INFORMATION (Page 2 of Application Addendum)

Check "yes or "no: Has any member of your practice had a recoupment by Georgia Medicaid of over $5,000 in any 18-month period? **If "yes", please attach explanation of recoupment.**

List all physicians, nurse practitioners and physician assistants in the practice who wish to participate in GBHC. Enter the name(s) of the medical personnel, Medicaid provider number* and Georgia professional license number. Check "yes" or "no" if Board Certified and list specialty. Enter the number of hours each provider works per week at this location. Enter the primary hospital for each physician that ha hospital admitting privileges. If the individual physician does not have hospital admitting privileges, attach documentation that details his / her alternate arrangement for elective admissions for his / her patients. You may photocopy this page as necessary for additional listings.

* *If the practice is a rural health clinic, enter the rural health clinic Medicaid number beside each provider listed on the application instead of their individual Medicaid provider number. All other information requested must be completed for each member listed.*

Applicant's Name & Title: Enter the applicant's printed or typed name, title, signature and date the application was completed. If a group practice, the signature of an authorized representative is acceptable. **Original signature required.**

ATTESTATION STATEMENT

Provider's Name: Enter the name of the provider listed on page two of the application. For group practices, each medical provider listed on the application must complete a separate Attestation Statement. Enter the date the Attestation Statement was signed. The provider should sign on the signature line. **Original signature required**.

AFTER HOURS TELEPHONE COVERAGE & PROVIDER AVAILIBILITY AGREEMENT

Provider Information: Print or type provider or practice name, GBHC number and daytime and after hours phone numbers.

Office Hours: **List only those office hours when a provider is available in the office to see patients**. Include lunch breaks when you do not provide routine medical care.

After Hours Arrangement: Provide detailed description of the after hours coverage arrangements currently in effect.

Signature and Date: **Original signature only.**

MAIL COMPLETED PACKET TO:

(Or signature pages and supporting documents only, if applicable)

ACS Provider Enrollment Unit
PO Box 4000
McRae, GA 31055

APPLICATION FOR PARTICIPATION

GEORGIA BETTER HEALTH CARE

ACS Provider Enrollment Unit
P.O. Box 4000
McRae, GA 31055
(404) 298-1228 Or 1-800-766-4456

Complete this form and return it to the Georgia Better Health Care (GBHC) plan office at the address listed above. You will receive written notification when you have been approved. Thank you for your interest in Georgia Better Health Care.

PRACTICE INFORMATION

PRACTICE NAME_____

PRACTICE STREET ADDRESS _____SUITE_____

CITY _____COUNTY_____STATE _____ ZIP CODE _____

OFFICE TELEPHONE (_____)_____ OFFICE FAX NUMBER (_____)_____
To be listed on GBHC Member's Medicaid Card

AFTER HOURS TELEPHONE (_____)_____EMAIL_____
To be listed on GBHC Member's Medicaid Card

MAIL-TO ADDRESS_____

CITY _____COUNTY_____STATE _____ ZIP CODE _____

TAX ID _____ SOCIAL SECURITY NUMBER _____

Check One: ☐ **ACCEPTING NEW PTS** ☐ **ESTABLISHED PTS ONLY**

Patient Type: **IM/FP** ☐ **M/F 0-99** ☐ **M/F >14** ☐ **M/F 2-99** ☐ **M/F >21**
PEDS: ☐ **M/F < 19** ☐ **M/F < 22**
GYN: ☐ **>14** **Female Only**

Note: Effective 1/1/05, GBHC applicants who care for members under the age of 22 must either be enrolled or in the application process (as verified by receipt of an application) in the Georgia Medicaid Health Check Program.

Languages spoken (primary language first) _____ _____ _____

PLEASE INDICATE ANY OF THE FOLLOWING SERVICES WHICH YOUR PRACTICE MAY BE ABLE TO PROVIDE (check all that apply)

☐ Sign Language ☐ Wheelchair Accessibility ☐ Diabetes ☐ Asthma ☐ Other:_____

THE PERSON IN YOUR PRACTICE WHO SHOULD BE CONTACTED REGARDING GBHC ISSUES:

CONTACT PERSON: _____ TITLE:_____

CONTACT PERSON TELEPHONE #: (_____)_____ FAX#: (_____)_____

FTES: PHYSICIANS_____ NURSE PRACTITIONERS_____ PHYSICIAN ASSISTANTS_____
(Full Time Equivalent, i.e., minimum of 30 hours per week delivering direct patient care)

Has Georgia Medicaid ever placed any member of your practice on prepayment review status? ☐ Yes ☐ No
(If "yes", please attach details.)

Has any member of your practice had a recoupment of over $5,000 in any 18-month period? ☐ Yes ☐ No
(If "yes", please attach explanation of recoupment.)

Please list all physicians, nurse practitioners, and physician assistants in the practice at this location who wish to participate in GBHC. *

PROVIDER NAME	MEDICAID PROVIDER #	LICENSE #	BOARD CERTIFIED/ SPECIALTY	HOURS/WK This Office	HOSPITAL ADM PRIVILEGES/ OR Alternative arrangement** (Specify)
			Yes No Specialty:		Facility: From: To:
	Alternative Arrangement:				
			Yes No Specialty:		Facility: From: To:
	Alternative Arrangement:				
			Yes No Specialty:		Facility: From: To:
	Alternative Arrangement:				
			Yes No Specialty:		Facility: From: To:
	Alternative Arrangement:				
			Yes No Specialty:		Facility: From: To:
	Alternative Arrangement:				

***Individuals not currently participating with Medicaid who wish to participate in GBHC must also complete a Medicaid application. Please call Provider Enrollment at (404) 298-1228 or (800)766-4456 to obtain a Medicaid Provider Enrollment packet. This information is also available at http://www.ghp.georgia.gov .**

****GBHC PCPs must have hospital admitting privileges, or must have a formal arrangement with a physician who does have hospital admitting privileges and who agrees to abide by the GBHC authorization requirements. Please indicate the hospital where you have your primary admitting privileges or provide a description of your alternative arrangement.**

This practice is applying to participate as a primary care case manager in the Georgia Better Health Care plan.

_____ _____ _____

APPLICANT NAME (PLEASE PRINT) **APPLICANT SIGNATURE** **DATE**

GBHC
Georgia Better Health Care

Georgia Better Health Care
Primary Care Provider
After-Hours Telephone Coverage & Provider Accessibility Agreement

Georgia Better Health Care (GBHC) requires that participating Primary Care Case Managers provide patients with a method to contact the practice 24 hours a day, 7 days a week. The after-hours telephone line must connect or direct callers to the live voice of on-call **medical** personnel who will provide medical advice or triage, and either provide directly or refer members for necessary medical treatment. Access to after-hours medical advice and triage is intended to reduce fragmented, episodic care and unnecessary utilization of hospital emergency rooms for non-emergency care. (See Part II Policies and Procedures for Georgia Better Health Care services, **§ 902.5** on page 2 of this form) Additionally, providers must be available in the office to provide general medical care for a minimum of thirty (30) hours per week for primary care services. (See **§ 902.4** on page 2.)

Please complete the following:

_____ _____
Provider/Practice Name (type or print) GBHC Number

_____ _____
Daytime Office Telephone Number After-hours Telephone Number

Office Hours: **(Please indicate only those times a primary care provider is available in the office to see patients.)**

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open							
Close							
Lunch	To	To	To	To	To	To	To

Please provide below a step-by-step description of the after-hours coverage arrangement in effect for your practice in accordance with GBHC contractual requirements. Please include all applicable information as referenced in **§ 902.5**. Attach additional page(s) if necessary.

CERTIFICATION

I certify that the information provided is an accurate and complete description of the 24-hour after-hours coverage arrangement and hours of Primary Care Provider (PCP) accessibility in effect for this practice at this location. I further agree that any change in the after-hours telephone number or hours of PCP availability will be communicated, in writing, to Georgia Better Health Care at least (sixty) 60 days prior to the effective date of the change. I understand that failure to comply with all 24-hour coverage and PCP availability requirements may be grounds for termination as a primary care provider in the GBHC program. I further understand that I have the right to request an administrative review as specified in Part I, Chapter 500 of the Policies and Procedures Manual for the Georgia Department of Community Health should the Division of Medical Assistance chose to terminate or deny my participation in the GBHC program.

Signature (Provider or Authorized Representative) Date

From **Part II Policies and Procedures for Georgia Better Health Care Services**:

902.5 Maintain accessibility to GBHC members **during office and non-office hours (24 hour, 7 days per week, 365 days a year)** by means of telephone. During office hours, the telephone must be answered in a manner that will direct callers to a live voice. During non-office hours, an answering machine, answering service or automated system that follows the standards listed below, may be used:

- Answering machine or any other appropriate automated telephonic system may be used. However, the system must direct callers to a live voice. Live voice may include use of an answering service that will immediately contact on-call **medical personnel** who will appropriately triage the call. **Use of only non-medical personnel does not meet GBHC program requirements.**
- If a pager/beeper is used, a clear message directing the caller must precede the signal or "beep" prior to paging. The message must be recorded in English. Other foreign language messages may be used in addition to the English language, as appropriate for the practice.
- Hospital emergency departments may serve as the **after-hours** coverage if the appropriate medical personnel are available to provide telephone advice and triage. However, blanket authorization by the PCP for all their GBHC members to be seen in an emergency room setting for routine care **does not** meet GBHC program requirements. The PCP must be accessible to emergency personnel for telephone consultation as described below. **Written verification of an after-hours coverage arrangement between a PCP and a hospital emergency department is required**. **[Please attach to application.]**

Members requiring emergency services should be immediately directed to an appropriate emergency medical facility.

Members requiring non-emergency services should be given information about accessing services or advised how to handle medical problems during non-office hours. (Section 805 of the Policy and Procedure Manual provides an explanation of emergency and non-emergency services.)

The PCP, or designated medical personnel, must return telephone calls made by hospital emergency rooms for purposes of medical consultation or obtaining medical history within **one (1) hour** from the time the call was made.

Telephone calls from other providers should be returned as soon as possible **on the day the call was received** by the GBHC provider.

902.4 Be available in the office to provide general medical care for a minimum of thirty (30) hours per week for primary care services. If there are multiple locations enrolled in GBHC, a physician, nurse practitioner, or physician assistant must be present in each location for a minimum of thirty (30) hours per week.

Attestation Statement

1.

I hereby elect to participate in the Georgia Better Health Care (GBHC) program as a primary care provider (PCP) to deliver services to eligible Medicaid and PeachCare for Kids members. I certify that I am legally qualified and licensed to render the medical or remedial care or services authorized to be reimbursed under the GBHC category of service.

2.

I certify that the information in this application addendum is a true, accurate and complete description of the practices in effect for this practice. I understand that falsification, omission or misrepresentation of any information in this enrollment package will result in a denial of enrollment, the closure of current enrollment, and the denial of future enrollment requests, and may be punishable by criminal, civil or other administrative actions.

3.

I agree that any change in the after-hours telephone coverage arrangement or hours of primary care provider accessibility will be communicated, in writing, to the Department at least sixty (60) days before the change takes effect. I understand that failure to comply with all 24-hour coverage or provider accessibility requirements may be grounds for termination as a participating PCP in the GBHC program.

4.

In the event that I wish to discontinue any further participation in the Georgia Better Health Care program, I agree to give sixty (60) days written notice to the Department of such election to discontinue participation

5.

I understand that the complete text, as now or hereafter amended, of the Department's Policies and Procedures Manual relating to Georgia Better Health Care is hereby incorporated, by reference, into this instrument. And that, otherwise, there are no promises, terms, conditions, or obligations other than those contained herein, and this agreement shall supersede all previous communications, representations or agreements either verbal or written, between the applicant and the Department of Community Health, Georgia Better Health Care Program.

6.

In consideration for case management services I elect to render pursuant to this agreement, the Department shall reimburse for such claims, and in such amounts, as meet the provisions of the Georgia State Plan for Medical Assistance, and the applicable terms and conditions for receipt of Medical Assistance published in the Georgia Better Health Care Policies and Procedures Manual and amendments thereto, in effect on the date the service is rendered.

_____

Printed Name of Applicant

_____

Signature of Applicant Date